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South Carolina Medical Association

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- SUMTER NUMBER -

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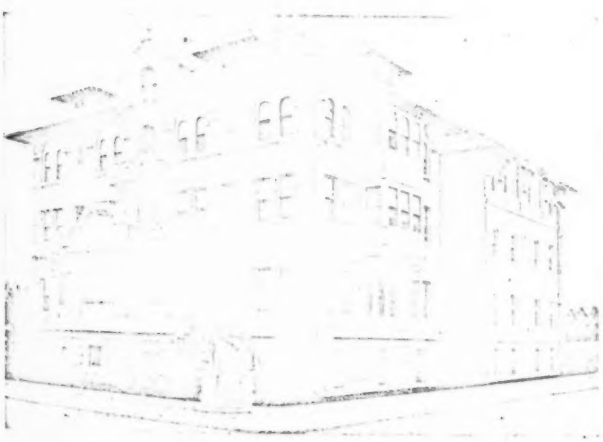

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SUCCESS in Artificial Infant Feeding depends largely upon the kind of food selected, and *co-operation* with the mother.

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Baby's Bath
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Manufacturers of Infant Diet Materials

The Journal
OF THE
South Carolina Medical Association

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EDITORIAL

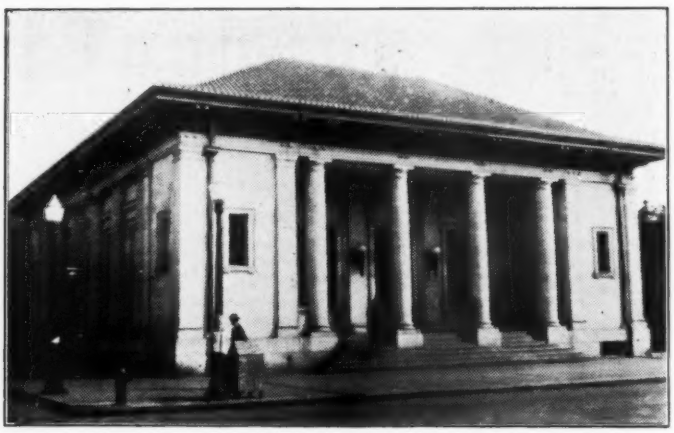
ON TO SUMTER, APRIL, 6, 7, 8, 1926.

The City of Sumter and her people have had the privilege and pleasure of being hosts to the South Carolina Medical Association, in annual convention on several occasions, but not in recent years; therefore the 1926 meeting of the Association in this city is anticipated with keener pleasure than ordinary and the welcome that will be extended to our guests by resident members of the Medical Fraternity and by the community as a whole will be as cordial as Sumter knows how to accord honored guests. We wish each one to feel at home and to enjoy his stay in the Gamecock City.

Those who have attended meetings here in former years will observe many changes in the Sumter of twenty-five or ten years ago—there have been developments and improvements with the passing years, and while the growth in population has not been as rapid or as great as in some other South Carolina towns, yet we feel that we can point with pride to the substantial betterments that have been made and the manner in which we have utilized the natural resources of this section.

Sumter is a city of beautiful homes and home surroundings, big trees and a luxuriance of flowers of temperate and semi-tropical growth. Its climate reaches no extremes of heat and cold. Its progressiveness is evidenced by its public improvements and organizations covering every phase of public affairs, and educational, religious and fraternal activities. It enjoys a large retail and wholesale business. Sumter has thirty-one miles of improved streets, of which 16.1 miles are hardsurfaced. Sanitary and storm sewerage installed throughout the entire city.

There is adequate electric power, current being sold at low rates, on a sliding scale, for both lighting and motor power for manufacturing purposes. Gas of 525 heat units is sold



U. S. POST OFFICE

by a private corporation for domestic and industrial uses.

Sumter is surrounded by a country that ranges from the high hills along the Wateree river to the flat lands of the coastal plains. Its soil is rich and grows a great variety of fruit and vegetables, of both the semi-tropical and temperate zones. An abundant and never failing supply of artesian water is obtainable at minimum cost from flowing wells in more than one-half the area of the country. Pure, soft water obtainable from springs and wells in all sections.

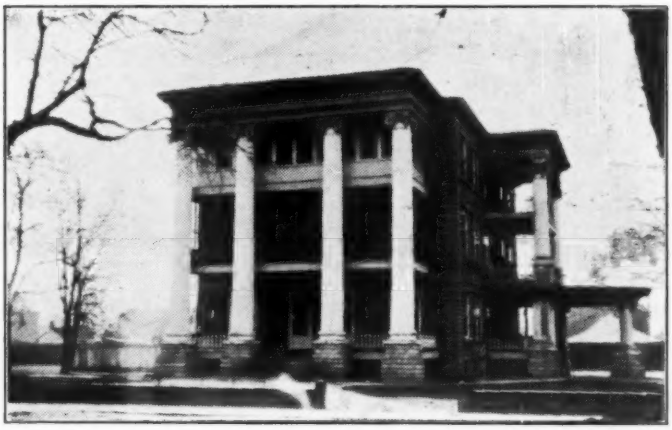
Sumter county with an area of 574 square miles, has a population of 43,040, (Census of 1920) and is almost the geographical center of South Carolina, in the Upper Coastal Plain, and having an elevation ranging from about 100 feet to 450 feet above sea level. Sumter, a modern city of 12,000 population, is the county seat, located in the center of the county.

The United States Soil Survey bulletin of Sumter county gives the lowest mean temperature 45 degrees in January and the highest mean temperature 79 degrees in July. The average for the year is 63 degrees and the average annual rainfall is 44.4 inches. Sumter temperature rarely is higher than 90 degrees and seldom below 32 degrees. The mortality rate for 1922 was 16.1—white 5.4, and colored, 10.7. Only one white person died of tuberculosis and none from typhoid fever. The sick and injured receive excellent attention at a modern hospital.

Sumter's industries include lumber mills, (including hardwood) veneer and ply-wood, caskets, fancy brick, radio receiving sets, hangers for wardrobe trunks, saw mill machinery, canned spinach, beans, tomatoes, okra, sweet potatoes, figs and grapefruit; cream, ice, mattresses, automatic sewer flushers, steam laundry, sheet metal products and tobacco flues. Sumter's hardwood and veneer go to the wood working trade throughout the country.

No better railroad facilities are enjoyed by any town or county in South Carolina—the Atlantic Coast Line, Southern Railway, Seaboard Air Line and the Northwestern Railway of South Carolina passing through Sumter and traversing the county in all directions, thus afford convenient shipping points for practically every neighborhood.

Sumter county has complete and well planned hard surfaced highways. There are ten main highways, radiating from the city of sumter that reach every section of the county and connect with the State Highways. In this system of asphalt surfaced, concrete base roads, there are 137.8 miles making Sumter county the best paved county in the entire South and offers the farmer unexcelled facilities for getting his products to the markets. Two creameries, three ice cream plants, a cannery, (all prospering) furnish markets for dairy and trucking products at top notch prices.



TUOMEY HOSPITAL

The educational facilities of Sumter's public schools are foremost in the state. The record set and maintained for years has given Sumter first place and its scholarship ranks among the best in the country. Separate schools are maintained for colored children and the sexes are segregated. Industrial training is given and a uniformed military organization is maintained for the boys of the high school. An educational institution of merit and long standing is St. Joseph's Academy, founded in 1863. It is maintained by the Roman Catholic Church.

There are also excellent primary and grammar schools throughout the county, with accredited High Schools at Mayesville, Pinewood, Wedgefield and Dalzell. The paved highway system renders access to the high schools of the City of Sumter easy for the children of the rural districts and more than a hundred living within a radius of more than ten miles have attended the city schools regularly since the paved highways were completed.

The Sumter Hospital was founded in the year 1903, and was jointly owned and operated as an institution to care for the sick, by the following gentlemen: Dr. S. C. Baker, Dr. A. China, Dr. W. Cheyne and Dr. H. M. Stuckey. Later, the building changed hands, having been purchased by the trustees of the Tuomey Estate. On February 9th, 1914, the Tuomey Hospital was incorporated, and ever since, has served the community needs. The Hospital was the gift of Mr. Tuomey to the City of Sumter, for the purpose of protecting public health, by modern scientific methods. With a fifty bed capacity, and a daily average of thirty patients, the institution is fast outgrowing it's size. Plans are under consideration for the erection of a new wing and other facilities to meet increasing demands of the public and the profession.

The Board of Directors of the Tuomey Hospital, consists of three life-time members, three members of City Council, and one County resident. Messrs. Neill O'Donnell, I. C. Strauss, and H. M. Stuckey, M. D. are the present life-time members.

The Committee on Arrangements, Dr. C. J. Lemmon, Chairman.

PROVISIONAL PROGRAM
FIFTH ANNUAL MEETING
SOUTH CAROLINA PUBLIC HEALTH ASSOCIATION

Sumter, S. C., April 6, 1926.—10:00 A. M.

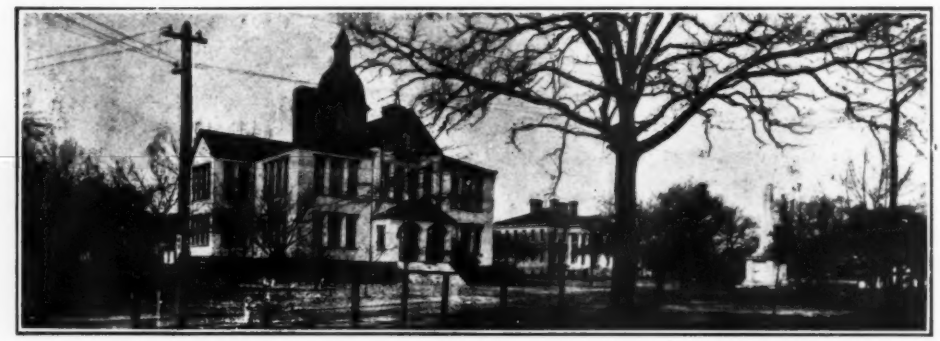
President, R. G. Beachley, M. D., Spartanburg, S. C.; Vice-President, P. G. Hasell, C. E., Columbia, S. C.; Secretary-Treasurer, Theresa Lightsey, R. N., Newberry, S. C.

MORNING SESSION: Place of meeting to be announced later.

Address of Welcome—His Honor, R. D. Epps, Mayor of Sumter.

Response—Dr. James A. Hayne, Secretary and State Health Officer.

Scientific Basis for the Control of Certain



PRIMARY SCHOOLS

Communicable Diseases—Dr. Wallace Poole, Health Officer, Cherokee County.

Instruction of Midwives as Carried on by South Carolina State Board of Health—Miss Katherine Malone, Midwife Supervisor.

Public Health Administration—Dr. H. B. Neagle, Prof. of Preventive Medicine, Univ. of Georgia Medical School Augusta, Georgia.

Subject Unannounced—Dr. James A. Hayne.

The Metropolitan Life Insurance Company as a Great Welfare Organization—Miss Monica Moore, Metropolitan Supervising Nurse Southern Territory.

How Shall We Handle Our Tuberculosis Problem in the South?—Dr. P. P. McCain, Supt. North Carolina Sanatorium, Sanatorium, North Carolina.

How Your Red Cross Chapter Can Aid in Promoting Public Health—Miss Katherine Myers, A. R. C. Field Representative for the Carolinas.

LUNCHEON—1-2.

AFTERNOON SESSION: Open Discussion Election of Officers.

Business Meeting.

PROVISIONAL PROGRAM 78TH ANNUAL MEETING SOUTH CAROLINA MEDICAL ASSOCIATION, SUMTER, S. C., APRIL 6, 7, 8, 1926.

Wednesday, April 7th

Address in Surgery—By Dr. Stuart McGuire, Richmond, Va.

Reading time 15 minutes including slides. Discussions five minutes.

Symposium on Hyper-thyroidism.

1. The Etiology and Symptomatology of Hyperthyroidism.—By Dr. Robert Wilson, Charleston, S. C.

Discussion opened by—Drs. G. R. Wilkinson, Greenville, S. C., and J. H. Gibbs, Columbia, S. C.

2. The Diagnosis of Hyperthyroidism.—By Dr. T. R. Littlejohn, Sumter, S. C.
   Discussion opened by Drs. C. J. Lemmon, Sumter, S. C. and F. H. McLeod, Florence, S. C.
3. The Non-Surgical or Medical Treatment of Hyperthyroidism.—By Dr. Hugh Smith, Greenville, S. C.
   Discussion opened by Drs. Walter Mead, Florence, S. C. and I. H. Grimball, Greenville, S. C.
4. The Surgical Treatment of Hyperthyroidism.—By Dr. LeGrand Guerry, Columbia, S. C.
   Discussion opened by Dr. J. H. Gibbes, Columbia, S. C.

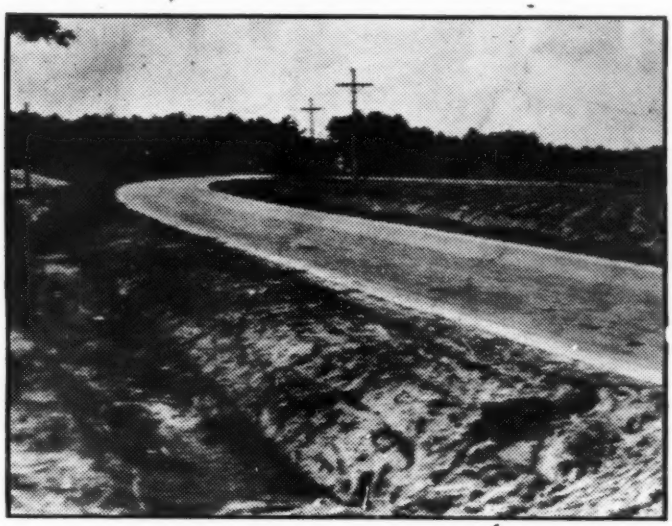
Thursday, April 8th, 9:30 A. M.

Symposium on The Nutrition of the Child.

1. The Nutrition of the Child a Function of the State.—By Dr. M. W. Beach, Charleston, S. C.

Discussion opened by—Drs. R. M. Pollitzer, Greenville, S. C., and W. E. Simpson, Rock Hill, S. C.

2. The Diet and Nutrition of the Child.—



By Dr. William Weston, Columbia, S. C.
Discussion opened by Drs. J. H. Gibbes, Columbia, S. C. and D. L. Smith, Spartanburg, S. C.

3. The Effects of Malnutrition on the Osseous and Nervous System of the Child—By Dr. E. L. Horger, State Hospital, Columbia, S. C.
Discussion opened by Drs. C. F. Williams, Columbia, S. C. and E. W. Barron, Columbia, S. C.
4. The General Nutrition of the Child and Focal Infections.—By Dr. I. H. Grimball, Greenville, S. C.
Discussion opened by Drs. R. M. Pollitzer, Greenville, S. C. and D. L. Smith, Spartanburg, S. C.

Periodic Health Examination Clinic Thursday, A. M. April 8th—By Dr. C. Ward Crampton, New York.
Volunteer Papers.

Subject to re-arrangement on Final Program.

1. Cholecystography.—By Dr. W. M. Sheridan, Spartanburg, S. C.
2. Diagnosis and Treatment of Vincent's Infection as it Pertains to the Mouth and Throat—By Dr. L. O. Mauldin, Greenville, S. C.
3. Spastic Paralysis its Orthopedic Treatment and Management.—By Dr. William A. Boyd, Columbia, S. C.
4. What I believe About Pellagra After Having Had It.—By Dr. Baxter Haynes, Spartanburg, S. C.
5. Results of Severe Abdominal Contusion with Case Reports.—By Dr. Julius H. Taylor, Columbia, S. C.
6. Rabies in the Human,—Case Report.—By Dr. W. G. Gamble, Florence, S. C.
7. Lung Abscess with Lantern Slides.—By Dr. N. B. Heyward, Columbia, S. C.
8. Syphilis and the Wassermann Reaction as Done by the South Carolina State Board of Health.—By Dr. J. Heyward Gibbes, Columbia, S. C.
9. Sialolithiasis.—By Dr. John F. Townsend, Charleston, S. C.
10. Are the Doctors Keeping Faith with the Mothers of To-day.—By Dr. Willard C. Hearin, Greenville, S. C.
11. The Surgical Treatment of Duodenal Ulcer.—By Dr. B. H. Baggott, Columbia, S. C.
12. The Treatment of Fractures about the Upper End of the Humerus.—By Dr. James McLeod, Florence, S. C.
13. Fungus Diseases of the skin.—By Dr. J. Richard Allison, Columbia, S. C.

14. Maxillary Sinusitis, with Lantern Slides. —By Dr. Walter J. Bristow and Dr. Thomas A. Pitts, Columbia, S. C.
15. Artificial Pneumothorax, with Report of Cases.—By Dr. W. A. Smith and Dr. R. B. Taft, Charleston, S. C.
16. Tularemia.—By Dr. W. R. Wallace, Chester, S. C.
17. Some Observations on a Series of Cesarean Sections.—By Dr. Robert E. Seibels, Columbia, S. C.
18. The Etiology, Pathology, Diagnosis and Treatment of Infections of the Kidney, Other Than Caused By the B. Tuberculosis.—By Everett E. Herlong, M. D., Florence, S. C.
19. Some of the Aspects of Chronic Appendicitis.—By Dr. Wm. Buck Sparkman, Greenville, S. C.
20. Diagnosis and Treatment of Ureteral Calculous.—By Dr. T. M. Davis, Greenville, S. C.
21. The Kahn Test for Syphilis.—By Dr. F. B. Johnson, Charleston, S. C.

NEWBERRY PROGRESSIVE

The Secretary-Editor attended the public as well as the Medical Society meeting at Newberry April 11th and was keenly impressed with the activities going on there. Dr. W. S. Rankin of the Duke Endowment outlined the plans of that organization in a very able address before the public. Following this meeting a delightful banquet was served at the Newberry Hotel for the members of the County Society and invited guests. Dr. Le Grand Guerry of Columbia delivered an admirable address on the mortality of appendicitis. The real object of the occasion was to inspire further interest in the splendid new hospital just opened. The subject of County Hospitals, has taken on a most hopeful attitude since the magnificent gift of the late Mr. J. B. Duke will make it possible for practically every county in the Carolinas to own and operate such an institution. The Newberry Hospital is a model for other counties to consider.

The fine spirit of cooperation on the part of the citizens of Newberry may also be considered as a model worthy of imitation.

ORIGINAL ARTICLES

THE TRANSFUSION OF BLOOD

By James McLeod, M. D., Florence, S. C.

The literature on the subject of blood transfusion is so plentiful that any attempt to review it would leave no room for the chief purposes of this paper, which are as follows:

(1) To present a method of blood matching that we have extensively employed, and which we believe to be the most efficient of all methods of testing for compatibility, as well as the most rapid and simple.

(2) A method of transfusion that employs only whole, unmodified blood, and has in our opinion certain distinct advantages over the Citrate method used in many places.

(3) The importance of transfusion not only in imperative cases—but also as a prophylactic and a therapeutic measure.

My experience with this method of matching and transfusion covers a period of two and one-half years and embraces 250 transfusions,—175 of which were done while I was on the Surgical Service of Bellevue Hospital in New York, and the latter 75 at The Florence Infirmary in Florence, during the past nine months. Although all facilities have been at hand for other methods of transfusing blood, they have been discarded in favor of the method about to be described, either because of mechanical or technical difficulties or unpleasant after effects.

The ease with which type of transfusion can be done and the uniformity of results obtained has done much to overcome the prejudice against transfusions which was the direct consequence of frequent chills, sharp rises in temperature. and other foreign protein reactions. Gradually the medical profession is coming to regard a transfusion as a procedure fraught with no more serious consequences than that of ordinary intravenous medication, and having infinitely greater therapeutic possibilities. This impression will gain strength only so long as painstaking care marks every step of the blood matching and technique of transfusion.

The method of matching which we use is

Read before the South Carolina Medical Association, Spartanburg, S. C., April 23, 1926.

based primarily on the macroscopic agglutinating test described by Vincent in the J. A. M. A. for April, 1918. This has been variously modified until the following method has been devised: Five to ten c. c. of blood are withdrawn from the recipient's arm, shaken vigorously to defibrinate, centrifuged, and the supernatant serum withdrawn. The cells are then shaken with an equal volume of sterile physiological salt solution and again centrifuged. Meanwhile, the donors are assembled and a drop of whole blood from the ear lobe or finger of each is taken on a glass slide and mixed with four times its volume of the recipient's serum. Agglutination as seen by the naked eye immediately throws the individual out of consideration as a prospective donor. We find this step a distinct time-saving device, as it takes only one or two moments to rule out an unfavorable prospect. When no agglutination occurs, blood is taken from the arm vein of the prospective donor, shaken, centrifuged and the cells again washed with saline as was done in the case of the recipient. After a second centrifuging, the supernatant saline is removed from the cells and enough fresh saline added to make approximately a 50 per cent dilution. Cross matching is now done using one drop of cell suspension to four drops of serum. No tube or ice-box method is employed to confirm this and no microscopic examination is permitted. We believe both of those procedures to be potential sources of error. The result is always checked by a second experienced man.

Except in cases of dire emergencies, we prefer to disregard the existence of "universal donors" and "universal recipients" and insist on absolute freedom from agglutination on each side of the cross matching. It will be noted that nothing has been said about blood groups. It is unnecessary by the above method to ascertain the group to which either donor or recipient belongs,—such classification is necessary only when a large number of professional donors is on call, and even then the same cross matching must be carried out.

Let me emphasize here the importance of certain features of the method just described which we have found to be essential to its success. (1) Washing of cells in physiological saline; (2) having a marked excess of the serum when testing for agglutination; and (3) discarding the tube method and microscopic examination as tests for agglutination. We believe that, provided an excess of serum is present in the mixture, incompatibility, if present, will manifest itself within one or two minutes by an agglutination visible to the naked eye.

Needless to say, other precautions are also necessary to insure the suitability of the donor. A negative Wassermann should be insisted on in professional donors, while in volunteer donors it is frequently sufficient to secure an unquestionably negative history, provided he understands his responsibility in the possible transmission of lues. In doubtful cases a hemoglobin estimate should also be done on the donor. We encountered one man in New York whose hemoglobin had dropped to 40 per cent as result of too frequent blood donations. Nevertheless, he presented himself as a donor in answer to an ad inserted in the newspapers but after the detection of his condition he was promptly admitted to the medical service of the hospital and ultimately participated in a transfusion,—this time in the role of recipient, however.

The actual transfer of blood is done by the Linderman Syringe cannula method. Briefly described, the technique is as follows: The apparatus consists of two Unger cannulae, three basins of about two quarts capacity each, and three 20 c. c. Record syringes. The patient and donor are placed in parallel positions in the recumbent posture. The skin of the arms is then painted with dilute iodine from wrist to shoulder, and with sterile sheets and towels the donor and recipient are then draped, leaving exposed the ante-cubital space for the introduction of the cannulae. Between the recipient and donor there is placed a small table which holds the three basins, the first of which contains distilled water, and the other two sterile physiological salt solution, at approximately room temperature, which is to serve for washing the syringes. A nurse stands behind the table and washes the syringes by rinsing each syringe in each one of the three basins. The washing is done very rapidly, and the third basin must remain clear throughout

the transfusion. The cannulae are then introduced into the vein of the donor and the recipient, using a small drop of 1-2 per cent novocain in the skin at the site of introduction of the needle. The syringe is then filled from the donor, and placed upon the table. The operator handling the recipient picks it up and injects it through the cannula as quickly as possible. He then replaces it on the table and the nurse washes it as described.

The chief precautions to be observed are the avoidance of air in the syringes, and the blowing out of all residual saline. While the old theory of pulmonary embolus formation by air in the veins has been fairly well dissipated, there is good reason to suspect that air, like saline, acts as a foreign substance within the vascular system, and as such may give rise to temperature reactions.

The disadvantages of this method are: (1) It is purely a hospital procedure. (2) It requires the services of two doctors and a nurse. Far outweighing these, however, in our opinion, are the merits of the procedure. (1) There is practically no trauma to the blood in handling. (2) There is a minimum of foreign material with which it comes in contact. (3) There are no valves or stop cocks around which blood may clot, and no rubber tubing or blind system into which air may leak. (4) There are absolutely no mechanical difficulties to be overcome. (5) It necessitates the admixture of no anti-coagulants or foreign substances of any sort. (6) The method is rapid, —the average time to complete a 700 c. c. transfusion is 10 minutes,—and in this series 700 c. c. has been the average quantity transfused.

It will be seen at once that in these respects it is a distinct improvement over the Citrate method, and in the end results there can be no question of its superiority over the latter method. The outstanding objection to the use of Citrate Transfusions is the frequency of dangerous reactions. These occur in from 20 to 50 per cent when this type of transfusion is employed. When present, a chill comes on from 30 to 45 minutes after the operation and frequently begins while the blood is still flowing into the vein. A sharp temperature reaction usually follows the chill, and may be very high, and persist for several hours. In the 250 transfusions on which this paper is based, we have not had a single chill which could be attributed to the transfusion. In rare cases we have obtained a slight rise in temperature, coming on 24 hours after the transfusion and lasting only two to four hours. This has never exceeded one or two degrees.

The same freedom from reactions can be secured we believe by any method of transfusion which uses the macroscopic cross agglutination test and eliminates the use of anticoagulants, such as Sodium Citrate. The Unger method, with various modifications of his apparatus is the only other one commonly used which does not depend on the admixture of an anti-coagulant. We almost never employ this because of the comparatively complicated apparatus, and because it calls for the addition of a small, but nevertheless an appreciable, amount of saline.

Having discussed the methods of matching and transfer of blood, we will now pass on to a brief resume of the chief indications for its use. These might well be taken up under the head of Imperative, Prophylactic, and Therapeutic Transfusions.

By Imperative Transfusions, we mean those necessitated by acute blood loss, such as that occurring in large hemorrhages from trauma; bleeding gastric and duodenal ulcers; typhoid hemorrhages; placenta praevia; ruptured ectopic and post-partum hemorrhage. In this type of case there is nothing that will take the place of transfusion and in no cases are the results more gratifying or more spectacular. Here, transfusion is truly imperative and the sooner it is performed the greater the chance of recovery.

By Prophylactic Transfusion we mean preoperative transfusions to increase resistance for the contemplated surgical procedure. We have found such a measure most effective in reducing the surgical risk in cases requiring surgery but presenting a low hemoglobin, in cases where the operation is liable to be prolonged and require extensive handling of viscera, and in cases where the bleeding time is prolonged.

The Therapeutic transfusions far outnumber all the others. The use of new blood in the

treatment of blood dyscrasias, notably the primary anemias, leukemias, and purpuras is so well recognized that it requires no more than passing mention. We hold no brief for the curative value of transfusion in primary anemia or leukemia, but advise it simply as a palliative measure. It is frequently specific in purpura hemorrhagica. In the treatment of sepsis, the introduction of bactericidal chemicals into the blood stream offers a distinct danger to the parenchymatous organs which is not encountered in transfusions. Linderman states, "That in long standing cases of sepsis, even with bacteremia, the patient will frequently arrive at a point where his powers of resistance just about enables him to oppose further advance of the infection. The organism and the host then seem to exist side by side, until one of the two conditions prevail. The host will either overcome the organism, or the organism will advance further so as ultimately to overcome the host. During the stage of indifference, there may be very little, or a moderate or a severe grade of anemia, malaise or debility, sapremia and poor nutrition, with absence or poor development of granulations about the infected area. This may be regarded as a critical period in the disease of the patient, and all measures should be directed towards increasing the patient's resistance. Blood transfusion will frequently offer an excellent field for application in these conditions. Infection is controlled, sapremia is reduced, and granulations stimulated."

We do not believe that a septic type of temperature is in any sense a contraindication to transfusion.

The treatment of cases of chronic secondary anemia by blood transfusion is of recent origin, but I confidently believe that in the future no such case can be regarded as properly treated unless the benefits to be derived from a transfusion are considered. Here falls that very large group of cases that are anemic from chronic diseases,—as malaria, hook-worm, typhoid, sepsis, slowly bleeding ulcers, obstetrical and gynecological cases,—or any case which has gradually been debilitated over a period of time, and whose hemoglobin is around 40 to 50 per cent. They may be ambulatory in type, but go on for an indefinite time not possessing the necessary stimulus to build up their rather depleted system. These cases are treated by the general practitioner by the use of various forms of iron and arsenic. The disappointing results of this form of treatment have long been recognized but only recently scientifically proven by Whipple, who showed in 1920 that inorganic iron and arsenic have little or no effect on blood regeneration. An interesting set of cases bearing on this point was reported in this month's issue (April, 1925) of The American Journal of The Medical Sciences by M. L. Janes. Using the commonly employed preparations of arsenic and iron over a period of thirty days and on ten patients he obtained an average gain in hemoglobin of 5 per cent, while the red blood cells showed an average gain of 200,000 per cubic millimeter. These values he counts as negligible since they are within the limit of human error. Using the same patients he then performed blood transfusions at ten day intervals for a similar period of thirty days. Here he obtained an average increase in hemoglobin of 21 per cent, and 800,000 in red blood cells. With this latter treatment he also noted marked improvement in general health, which had not been true when treated with iron and arsenic. Thus he concludes that "Individuals suffering from Secondary Anemia due to acute or chronic disease regenerate hemoglobin and red blood cells more rapidly, more effectively, more completely, and within a shorter period of time by periodic blood transfusion than those receiving Inorganic Iron or Arsenic preparations."

In our series of transfusions a large number of the cases have belonged to this class, and we have had ample opportunity to corroborate these well controlled findings. Drawing deductions from this series of cases, I think we may summarize as follows:

(1) The macroscopic slide method of testing donors for compatibility is the most efficient of all methods, and has the added advantage of being very rapid and easy.

(2) The Syringe-Cannulae method of transfusion, where whole, unmodified blood is used, is much superior to the Citrate method.

(3) Using these methods we have not ob-

tained a single reaction of any consequence in the entire 250 cases.

(4) Transfusion in cases of Chronic Secondary Anemia is the most efficient of all therapeutic agents, and this field of cases constitutes the majority of our cases.

(5) Transfusion is no longer to be regarded as a time-consuming and dangerous procedure, but on the contrary represents a rapid, safe and most beneficial agent to that large field of cases to which it is applicable,—and in which it is indicated.

INTUSSUSSEPTION IN CHILDREN AND AN OPERATION TO REPLACE RESECTION IN LATE CASES.

By George H. Bunch, M. D., Columbia, S. C.

In a surgical work of 15 years we have had a dozen cases of intussusseption all in children. In the last 5 years we have had 5 cases and it is some of these that we intend to discuss in this paper. We all know that intussusseption is a form of intestinal obstruction in which one segment of gut telescopes into another. The condition is usually acute but may be chronic. Perhaps 95 per cent of intestinal obstruction in infants and young children is from intussusseption. It is rare in adults so that a study of intussusseption is really a study of intestinal obstruction in children.

The symptoms of acute intussusseption are sudden agonizing colicy pain which comes and goes as does the muscular contraction of the gut in its effort to overcome the obstruction. The child may awake screaming out of a sound sleep. Nausea and vomiting is the rule. There is a bowel movement which usually contains fecal matter but as soon as the gut has been emptied below the obstruction neither fecal matter nor flatus comes. There is tenesmus especially if the condition extends into the lower large bowel. The congested mucous membrane of the strangulated gut bleeds and subsequent movements are of blood and mucus. The acute strangulation causes shock and the little patient is apt to be in a state of collapse out of proportion to any evident cause for it. The abdomen is soft. There is neither rigidity nor marked tenderness. The telescoped gut makes a characteristic sausage shaped abdominal tumor that can be felt in 90 per cent of the cases. It is apt to be found to the left of the navel, and may often be felt by the finger in the rectum. When found the diagnosis is established. There is no acute abdominal condition with a more classical symptomatology and there should be none more readily recognized.

Read before the South Carolina Medical Association, Spartanburg, S. C., April 23, 1925.

The treatment of acute intussusseption is reduction of the telescoped gut by operation just as soon as the baby has reacted from the shock. Reduction is safe and easily accomplished when operation is done early. When left the gut tends to become gangrenous. Reduction may then be impossible. Unless operated upon early these little patients are overwhelmed by the toxemia and make poor operative risks.

Case 1. A well developed breast fed boy of 6 1-2 months was referred by a Pediatrician. The second day after birth the baby vomited blood several times, but an intramuscular injection of blood and calcium chloride stopped it. There was no bleeding from the bowel. Health had been good until 2 days before the present attack when he vomited several times. Next morning after an enema he passed a bloody stool. He vomited several times during the day. Next morning a bright red bloody stool was passed after rectal examination. No mass was detected either on abdominal palpation or rectal examination. At 12 o'clock under chloroform a sausage shaped mass was felt under the liver. We were asked to see the case and the operation was done at 5:00 P. M. It lasted 20 minutes. About 12 inches of the terminal ilium had become invaginated or telescoped through the ilio coecal valve into the colon. The patient was not eviscerated but by a gentle milking motion the small gut was not pulled but gently pushed back out of the large. At 6:00 P. M. the fever was 104 degrees but at 8:00 P. M. the baby was bright and passed a fecal stool free from gross blood. Thereafter recovery was prompt and without vomiting or temperature elevation and the baby left the hospital on the 5th day after the operation.

Comment: This case although operated up-

on over 2 days after obstruction from intussusception was in a remarkably good condition and the reduction of the mass was possible. We think the case should have been operated upon although the diagnosis may have been somewhat in doubt. The giving of chloroform in an attempt to palpate the mass and clinch the diagnosis we consider dangerous and unwise. It is a safer, saner proceedure to open the abdomen and be prepared to relieve the patient. There is but little danger in an exploratory incision and if it were resorted to oftener more lives would be saved.

Case 2. A colored boy of four years was admitted as a county case into the Good Samaritan Hospital on July 22, 1923 with the diagnosis of abdominal tumor. No accurate history could be obtained for the people were ignorant. The boy had been ill for 5 weeks with pain in the abdomen and vomiting which had become worse until nothing was retained. His bowels had not moved for some days. He was greatly emaciated and very weak. There was a boggy mass twice the size of a man's thumb extending across the abdomen in the shape of an inverted letter U. This mass outlined the large intestine and at operation 15 inches of ilium were found invaginated through the ilio-coecal opening, extending up through the ascending colon, through the transverse colon, and well down into the descending colon. The finger on rectal examination failed to reach the mass but came away bloody. Enemas returned blood stained but without fecal matter. At operation, although the gut was swollen and oedematous, by patient manipulation the intussusseption was reduced, the appendix and the coecum coming out with the last of the ilium. In this case there appeared a decided tendency for the ilium to go back into the colon and we sutured the mesentery of the ilium to the posterior abdominal wall to prevent recurrence. The patient made an uneventful convalescence except for an infected wound and the development of a post-operative hernia which has since been repaired.

Comment: This was a case of chronic intussusseption of 5 weeks duration. Evidently obstruction was not at first complete although it had finally become so, making operative relief imperative. The fact that the small gut could remain in this condition so long without becoming gangrenous or even adherent is remarkable.

Case 3. A well developed boy of 3 years had been healthy except for whooping cough when quite young. Four weeks ago he became sick and purpuric spots appeared over his skin and mucous membranes. He vomited blood and his stools were largely of blood. 10 C. C. of the mother's blood were injected deep into the gluteal muscles. In three days another 10 C. C. were given without much improvement in the patient. Three days later 10 C. C. of the father's blood were injected with marked improvement of the spots. In three days 17 C. C. of the father's blood were given with complete disappearance of the spots and with markedly lessened bleeding from the bowel, which with bleeding from the stomach and mouth had continued since the beginning of the illness. The child was improving in every way until Saturday, November 13, 1921 when he was taken with severe abdominal pain, vomiting, and tenesmus. This lasted for three hours after which the patient went to sleep and rested comfortably until Sunday morning. The abdomen had become distended during the night. He had not had a movement with fecal matter for 2 days. Enemas returned blood stained without flatus. The temperature had never been above 100 degrees, the finger in the rectum could not distinguish a tumor. The child was listless and in the attending physician's absence an internist was called who requested that a surgeon see the child. At 6:00 P. M. we saw the case. The abdomen was distended, the pulse was rapid, weak, and thready, the temperature was 99 degrees. The child was apathetic and extremely ill with a general peritonitis. In about an hour we operated upon him and found the abdomen filled with distended gut obstructed from a gangrenous intussusseption in the ilium about a foot and a half long. The gangrenous gut had perforated and set up a general peritonitis. We put a drain into the pelvis and closed the wound with the patient in extremis. He died early next morning.

Comment: Purpura hemorrhagica in this case so obscured the condition that the diagno-

sis of intussusseption for two days was missed by a well known Pediatrician until his patient was practically moribund and beyond help. The intestinal purpura must have been a causative factor in the development of intussusseption.

Case 4. While attending a district association meeting in a neighboring city on November 8, 1923 we were asked to operate upon a boy of 12 years who had always been constipated and subject to mild attacks of abdominal colic. The present attack had begun 4 days before with general abdominal pain and persistent nausea with vomiting. These symptoms continued, the pain tending to become localized to the left of the navel. There had been no bowel movement for 4 days since the attack began. The first enema returned with small fecal particles, subsequent enemas returned clear and without flatus. He had salts and oil every day with no results. There had been no passage of blood. Physical examination showed a pale, toxic boy with a weak pulse and a distended, rigid abdomen. On rectal examination a mass was felt high up on the left. At operation we were unable to reduce the intussusseption which was entirely in the ilium and resection of about 12 inches of gangrenous gut was done. The ends were closed and a side to side anastomosis done. The work was done under a local anesthetic supplemented by ether. The patient left the table in poor condition and died in a few hours.

Comment: Cathartics in acute abdominal conditions can only do harm and enemas should be given instead. From a surgical standpoint this case has been most interesting to us and a consideration of it has been the real reason for this paper. When intussusseption is recognized early and is operated upon early reduction can be done without evisceration or undue trauma to the intestine. Then the case has not become very toxic and the child stands the necessary manipulation very well. But when operation is done late after the patient has become toxic from acute intestinal obstruction plus dehydration from vomiting we have a poor surgical risk for even the simplest kind of operation. When an intussusseption cannot be reduced whether it be from oedema or adhesions or the gut has become gangrenous from strangulation, the surgeon at operation faces a problem whose solution is fraught with the greatest responsibility. When gangrenous the ideal proceedure is resection with anastomosis but such a severe operation in patients so weak and so toxic is followed by a mortality that approaches 100 per cent and is practically prohibitive. Several less severe proceedures have been suggested such as suturing the gut together at the first part of the intussusseption opening the outer gut longitudinally over the mass and removing the gangrenous gut from within the intussusseption, then suturing the incision in the outer layer of gut. This relieves the obstruction but is dirty, time-consuming and unsatisfactory. Since we attempted resection and lost the last case we reported, we have thought there must be a better, a safer way of doing these late cases. Recently in a negro boy of 10 years we had a strangulated inguinal hernia with a gangrenous loop of small gut that offered a problem almost identical with that of the gangrenous gut in intussusseption. We opened the internal inguinal ring and relieved the strangulation but believing our patient unable to stand resection we pulled the gangrenous gut through the ring and left the wound open, after sewing a rubber tube in the proximal gut for drainage. In a few hours the healthy gut adhered to the ring about it and our pathology was essentially extra-peritoneal. The gangrenous gut sloughed off and the patient went home well except for a fecal fistula which will probably close spontaneously. We do not believe that this case could have been saved in any other way.

This method is applicable to intussusseption and we believe it would save some of the late cases that we are losing by present methods. If we ever get another such case we shall endeavor to mobilize the mass and deliver it from the abdomen through the wound being contented at this time with doing nothing more than lightly closing the wound about the healthy gut of entrance and of exit, a tube being sutured in the gut above the mass to relieve the obstruction and to give drainage. There is but little shock to this proceedure. The pathology is made extra-peritoneal, the gangrenous gut is outside the abdomen, and the danger of peritonitis is practically eliminated.

SOME OBSERVATIONS AND CONCLUSIONS BASED UPON FIVE THOUSAND NON-SURGICAL DRAINAGES OF THE BILIARY TRACT.

By George M. Niles, M. D., Atlanta, Ga.

After a clinical experience embracing the above-mentioned number of non-surgical drainages of the biliary tract, certain conclusions—perhaps convictions—have been reached, which the writer will attempt to briefly summarize.

First: No physician can expect to obtain a high percentage of good results, which should last for several months or several years, unless he is completely "sold" on the value of this procedure in proper conditions, and is willing to infuse into his efforts a thoroughness and sincerity. A careless or indifferent technic, a mental attitude that would "damn it with faint praise," or its use in certain states, to be later mentioned, will result in disappointment to the patients, perhaps discouragement to the physician.

Second: Chronic cholecystitis or choledochitis, generally indicated by flatulence, digestive distress, a "muddy skin," lack of appetite, perhaps a history of malaria or influenza—such a syndrome, known under the rather loose term of "biliousness," which is used for the lack of a better word, offers a promising field for non-surgical drainage. Many of these patients have associated troubles, as chronic appendicitis, gastric or duodenal ulcer, pericholecystitic adhesions, etc., which gall-tract drainage cannot cure; but that part of the pathologic picture depending upon an infected gall-bladder or ducts, generally yields promptly to this treatment.

Third: Biliary stasis, with chronic infection of the gall-bladder following malaria, typhoid, constipation or some focal infections may properly receive this treatment.

Fourth: Sick-headache cases are either greatly benefitted or practically relieved by this method, though in migraine of long standing, quite a number of drainages will probably be required, and the course of treatment may need to extend over a considerable period of time. As many cases of chronic migraine have to a greater or lesser extent caused semi-invalidism, for years, the sufferer is generally willing to faithfully follow out this procedure, for often it offers the best chance of relief.

Fifth: Some forms of asthma, where the sensitization tests have not worked out satisfactorily, and where it seems probable that the underlying cause of this asthma abides in an infected gall-bladder will give remarkably good results from biliary drainage. Many asthmatics are nearly desperate, and it can do no harm to try this, though a certain percentage will yield no results.

Sixth: As an adjunct to other therapeutic measures, it is worth while in infectious joint troubles, though quite a number of drainages may be found necessary.

Seventh: In chronic catarrhal jaundice, where there is no material obstruction, such as a stone in the common duct, or a hydrops interfering, this method will frequently yield brilliant results. Occasionally a colic will follow and in a few instances, the ejection of small gall-stones has been accomplished. In one instance, the ejection of a large gall-stone followed a biliary drainage. This was duly reported and published in the Journal of the A. M. A.

Eighth: Patients with gall-stones can be made much more comfortable by these drainages, whether or not the gall-stones are later removed by surgery. Even after gall-stones are removed, it will be found helpful to have several drainages a few months after the operation. The writer has had a number of such cases in which biliary drainages were administered, pre—and post-operatively, and in every instance they seemed appreciative of the comfort derived.

Ninth: The writer believes that this method would be in order as a pre-operative measure in nearly all of the operations upon the gall-tract, though he has been unable, so far, to obtain much cooperation along this line from the surgeons.

Tenth: There are many patients who have had surgical gall-tract drainage, or have had the gall-bladder removed without permanent relief. Such patients may generally expect a liberal measure of relief from non-surgical drainage, and some, under the writers observa-

tion, seem to have attained perfect health, where surgery had proved unavailing.

Eleventh: In a certain proportion of gall-tract disease, surgery may be indicated, but for various reasons, may be inadvisable or inexpedient. Many of these cases can obtain amelioration of disagreeable or painful symptoms, with no risk. The writer has had under his care a number of aged individuals who were unable to withstand surgery, and others, where intercurrent affections precluded surgery, and in nearly every instance gall-tract drainage has proved itself worth while.

The assumption that this method will remove gall-stones, will break up adhesions, will cure appendicitis or cancer of the liver, or remove deep-seated organic pathology of the gall-tract is unwarranted and the patients should be so informed. In a number of cases, the writer has been placed in an embarassing position by having referred to him, by enthusiastic believers in this procedure, unsuitable cases, which non-surgical drainage could not hope to benefit.

Furthermore, in the opinion of the writer, no physician should employ this method unless he enters into it whole-heartedly, performing it in a technically correct manner, and is willing to persevere in his efforts, regardless of either active opposition, or lack of approbation from many of his confreres, whose good opinion he desires.

While neither the principle nor practice of non-surgical drainage is as yet universally accepted, there is, nevertheless, a growing number of conscientious physicians, who are properly employing it, and obtaining satisfactory results.

In conclusion, the writer is convinced that this procedure will enjoy a wider and wider acceptance as its merits become better known, and its limitations better understood, and that it will eventually reach a proper and honorable place as a recognized therapeutic procedure.

INTRACRANIAL HEMORRHAGE OF THE NEW BORN

By W. E. Simpson, M. D., Rock Hill, S. C.
(Representing the S. C. Pediatric Society)

Spread upon all the pages of medical history there are few, if any, sadder chapters than those that deal with the mentally deficient. Among the etiological factors in this lamentable condition, intracranial hemorrhage occupies a very prominent position.

No greater menace jeopodizes the life and the future well-being of the new born child than does intracranial hemorrhage with its trail of suffering, idocy, epilepsy, paralysis and death. Cerebral hemorrhage has been reported in as high as 50 per cent and, in one series 76 per cent, of the deaths of the new born. It can therefore be safely held responsible for one-half of the deaths occurring during the first few days of life. In addition to the deaths caused by intracranial hemorrhage, we must consider the cases that suffer to a greater or less degree, but who live and grow up, some apparently with no after-effects while others are seriously and permanently injured, both mentally and physically.

Read before the South Carolina Medical Association, Spartanburg, S. C., April 23, 1925.

ETIOLOGY:

Until comparatively recent years, intracranial hemorrhage was almost entirely attributed to injury sustained during birth, either due to prolonged pressure and congestion or manipulation and instrumentation. However, in more recent works, we find that in many instances the hemorrhage results from a general condition known as Hemorrhagic Disease of the New Born, in which many cases of extensive bleeding occurs where there has been no injury or damage to the cerebral blood vessels. Therefore under Etiology we will discuss those cases arising from the so-called hemorrhagic diathesis and those due to birth injuries.

The recent work of Rodda has greatly helped to eliminate causes other than a hemorrhagic diathesis from the large number of cases of intracranial hemorrhage. He has shown that if the bleeding and coagulation time falls within normal limits, the hemorrhage may be ascribed to some local cause. He states that the bleeding and coagulation time is gradually prolonged in the normal child for the first four days, usually returning to normal

on 5th or 6th day. The normal bleeding time is put down as 3 1-2 minutes and the normal coagulation time is 7 1-2 minutes—5 to 10 minutes the limit. In hemorrhagic tendencies the bleeding time may extend to hours and even days and the clotting time as long as 90 minutes. This explains the cause in those cases that are apparently normal at birth and on the 2nd to 4th day develop signs and symptoms of intracranial hemorrhage. The degree to which the process extends depends upon the changes in the blood formula and not so much upon the condition of the walls of the blood vessels. He offers as proof of this, the fact that the introduction of whole adult blood into the blood stream of the hemorrhagic infant, will, in all cases, materially inhibit and in most all cases, control the hemorrhage entirely and cause the return to normal of the bleeding and coagulation time. The usual causes given for this abnormal blood condition are anything that would produce abnormal stasis in the vascular system of the child, such things as pressure on the cord during labor, asphyxia, atelectasis and congenital defects of the vascular system. Some authorities suggest that the pressure exerted on the head during its passage through the birth canal may account for the abnormal blood condition. Others have noted that the condition has been apparently epidemic in certain institutions, naturally suggesting an infectious origin. These men believe the effect of the adult whole blood to be due to the introduction of some specific anti-bodies, rather then the introduction of coagulating elements. however, the bleeding and coagulation time will differentiate the hemorrhagic type from the traumatic type.

Intracranial hemorrhage of the traumatic type may be produced by unusually prolonged labor, hard and comparatively quick labor, precipitous labor, by excessive molding and overlapping of the cranial bones, difficult extraction of the after-coming head in breech-presentation and by difficult instrumental deliveries. The use of Pituitary extract also appears to be a very reasonable etiological factor.

During birth, the infant is exposed to a relatively high pressure, due to the labor contractions, and later to intra-abdominal pressure. The intrauterine pressure may amount to as much as 250 MM Hg. So long as the fetus is enclosed in the amniotic sack, the pressure is evenly distributed over the entire body and no injury occurs. However, after the rupture of the membranes and the passage of the head through or against the cervix, the labor contractions may become dangerous. Now the head is exposed to the atmospheric pressure which is so much less than the intrauterine pressure that the atmospheric is really a negative pressure and acts as a suction causing, particularly in dry labor, congestion of the parts exposed. This suction causes marked congestion and ecchymosis of the blood into the scalp and may be transmitted to the intracranial tissues and cause hemorrhages in the meninges or the brain substance. If to this be added the other unfavorable conditions such as excessive molding, extreme overlapping of the cranial bones or pressure from forceps, the likehood of hemorrhage is markedly increased. As far as our observation has carried us, the factor of dry labor has been present almost every time where we were certain that we had an intracranial hemorrhage. In both types of intracranial hemorrhage, prematurity, unusually small children, as in the case of twins, and the poorly nourished and feeble child, all seem to be decided predisposing factors.

PATHOLOGY:

The hemorrhage may occur at any place throughout the cranial cavity and may show a large single clot or may be diffuse. The most common location however, is beneath the tentorium over the cerebellum, but frequently they are found over the occipital lobes and may be found over the cerebrum. Hemorrhage into the ventricles has been reported. The hemorrhage may be limited to one hemisphere or extend to and involve both. The most usual location of the hemorrhage is in the pia and arachnoid. Small localized hemorrhages may be found beneath the pia in the brain substance. The source of the hemorrhage is also variable. It may come from multiple small points, from one of the veins entering some of the sinuses, from the rupture of one of the sinuses of the dura, due to overlapping of the bones, or there may be a laceration of the tentorium.

SYMPTOMS:

In pure cases of traumatic hemorrhage, the symptoms are present at birth or show up very shortly after birth. The later the symptoms occur, the less likely they are to be of traumatic origin. The symptoms in general are those of increased intracranial pressure or cortical irritation. If the hemorrhage is massive at birth, the child is usually still born or made to breathe only after prolonged efforts at resuscitation. Should resuscitation be successful, the child may apparently do well for a few hours and then show signs of increased intracranial pressure, manifested by restlessness, refusal to nurse, wakefulness, a characteristic whining cry suggestive of pain, accompanied by a strong, slow pulse, tense fontanels, palor, increased reflexes and later by twitching of one or more muscle groups and finally by convulsions, followed by stupor, and often death.

In severe hemorrhages of the intratentorial type, the child may die without convulsions, due to interference with the cardiac and respiratory centers. The most suggestive symptoms however, are refusal to nurse, restlessness, the whiny cry, followed by muscular twitchings. When the intracranial pressure is increased, you may have either dilated or contracted pupils with strabismus or nystagmus. Facial oedema is also usually present. If the hemorrhage is localized, the corresponding muscle groups are affected, thereby enabling one to locate the site of the hemorrhage.

There are frequently small hemorrhages in to the brain substance itself, which occur and give no symptoms until in later life when the spastic paralysis begins to show up and the signs of retarded mental development occur.

DIAGNOSIS:

The diagnosis of intracranial hemorrhage is easy in well marked cases, showing the characteristic symptoms referred to. In poorly marked cases, the only resort to cinching the diagnosis is by lumbar puncture, which should be done in all cases whether the diagnosis is clear or not. Bloody spinal fluid means intracranial hemorrhage, always, provided of course the puncture is not contaminated by the injury of the walls of the spinal canal.

PROGNOSIS:

The prognosis in all cases of intracranial hemorrhage is always very grave. Hemorrhages below the tentorium are probably always fatal, as are large hemorrhages in any location. If the hemorrhage is localized over the convexity of the brain and is not too large, it may be removed with good results. The most discouraging aspect of the proposition is that the exact extent of the injury cannot be forecast. An apparent complete recovery may, after years of seemingly normal development, show signs of spastic paralysis, arrested mental development, and finally, wind up as an epileptic or as an idiot.

TREATMENT:

No very satisfactory treatment has been found for intracranial hemorrhage of the traumatic type, but, as was suggested under etiology, cases of the hemorrhagic disease type can be prevented by careful attention to the bleeding and clotting time of the new born. This should be done on all new born babies, but it is imperative if there is any suggestion of an intracranial lesion.

Duke suggests the following method for obtaining the bleeding time. The heel of the child is thoroughly cleansed with alcohol and ether, with a sharp scalpel he makes a stab wound about .5 c. m. deep and with a piece of blotting paper gently wipes away the blood until it stops bleeding. The average time is from 2 to 5 minutes.

While this test is being done, we can test the clotting time also by the method suggested by Rodda: "With two thoroughly cleansed watch glasses and a No. 6 lead shot, a drop of blood is allowed to fall into one of the watch glasses which holds the shot, the other glass is placed over it and set aside. The glasses are gently titled every 30 seconds and when the shot ceases to roll in the blood and is held fast, the time is recorded as the clotting time." This is put down as 7 1-2 minutes or from 5 to 9 minutes as normal limits.

If the bleeding time goes over 5 or 6 minutes and the clotting time over 10 minutes, it is wise to test at least twice per day and, unless there is shortening of the time, it is advisable to give subcutaneously whole adult blood from one of the parents, unless the emergency is

great and then it may be given intravenously through the superior longitudinal sinus route. It is not necessary to type the blood, as it is an established fact that the blood of the new-born will not hemolize or agglutinate blood from a donor of any type. The size of the dose varies according to the condition to be met and ranges from 10 to 30 CC, repeated as circumstances require. Probably the best method is to draw from a vein of one of the parents into a 30 cc syringe through a needle, the required amount of blood and then inject it subcutaneously between the scapulae of the child before the blood has time to clot, strict aepsis being of course, observed. Gentle massage will facilitate the injection and prevent some pain as well as promote absorption. The blood will absorb almost altogether within a few hours. If the venous route is chosen, of course, citrated blood is used. The injection is made through the posterior angle of the anterior fontanel. The quantity given also depends on the condition requiring the transfusion and the effect on the patient.

In all cases of suspected intracranial hemorrhage, a lumbar puncture should be done both for diagnostic and curative purposes. The puncture, if properly done with the necessary aseptic precaution, can do no harm, but it will relieve the increased intracranial pressure and stop convulsions. The puncture should be repeated as often as increased tension is manifest. This within itself will save many cases that die from increased intracranial pressure.

The child should be kept warm and quiet, allowing as little handling as possible. It should be fed by hand upon expressed milk from the mother's breast. If it will not take milk from a spoon, a medicine dropper may be used and if that fails, it should be fed through a tube. Three to five grains of chloral hydrat per rectum may be given as often as necessary to produce rest and sleep. Combat dehydration by enemas, hypodermoclysis, etc. General careful nursing is a great factor in affecting recovery from intracranial hemorrhage.

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DISCUSSION

DR. R. M. POLLITZER, Greenville:

This whole subject of intracranial hemorrhage in the new-born is still in its infancy. A lot of work has been done on it in this country in the last five or ten years, and it is amazing how much we know, but we have a great deal to find out. I, for one, think there is a great deal to be positively proven. There is a lot we do not know about, and that is the relation between trauma and the clotting time. There are two things we are sure of—that intracranial hemorrhage of the new-born is extremely common, and that the diagnosis is not difficult if you do pay attention to the baby. If the nurse or doctor or family will notice that baby for a day or two after it is born, notice its crying and the way it nurses, you will find out a great deal about that baby. Notice the convulsions or slight convulsive tremors the new-born have.

As to treatment, of course lumbar puncture is good. Sometimes it does good; sometimes not. The important thing is to put in blood. If the case has been so damaged that the vital centers are destroyed, of course no amount of blood will be any good; the child will either die or become an idiot. The giving of blood is the important thing. It is too slow to put it in the muscle; I think you ought to put it somewhere else. One of the best places, I think, is the peritoneal cavity. You get a quicker result and you have a better chance than by just putting it in the muscle, because the amount you can put in the muscle is very limited and the absorption is rather slow.

DR. D. L. SMITH, Spartanburg, S. C.:

The subject of intracranial hemorrhage is one that is being taken up a good deal in the journals just at present. We did not understand this in past years as we do now. Dr. Simpson has presented a very concise and accurate statement of facts in regard to this trouble. Dr. Sharp, of New York City, has done a great deal of work along this line. He is just completing at present a series of one thousand cases of spinal punctures at birth, and he finds that fifteen per cent. of these children show blood in the spinal fluid. As Dr. Simpson stated in his paper, that is one of the diagnostic symptoms of intracranial hemorrhage in the new-born. Dr. Sharp is not stopping at this point, but has nurses who are following up these cases. He expects to follow them up for a period of ten years, to find if those children who show blood in the spinal fluid at birth will be affected in later years. The idea came to me that a child with some blood in the spinal fluid would have more or less hemorrhage in the brain, and would become a degenerate. Of course, degeneracy is

a broad term. I hope that Dr. Sharp will bring up something of real value. We have more of these babies, I think, every year—why I do not know, but certainly I see more of these intracranial hemorrhages each year. I do not know whether they are increasing in number or whether we just happen to see them. They are all unfortunate cases. If we can recognize the hemorrhage when the child is born, a great deal can be done for him to prevent the bad after results.

SURGERY

SAMUEL ORR BLACK, M. D., Spartanburg, S. C.

BRIEF CONSIDERATIONS OF THE SPLENOMEGALIES

The spleen is a hemolymph gland. Normally it lies high and to the rear in the left hypochondrium. It is about 4 1-2 x 3 x 1 1-4 inches in size.

It has a tremendous arterial supply—and when injured bleeds so furiously that unless the blood loss be checked death is almost ineventable.

Before birth this organ is a blood producing one forming both the white and the red blood cells but at or after birth this power is largely lost, though that it continues to form a few white blood cells is proven by the fact that the splenic vein contains the largest number of white blood cells of any vein in the body.

The spleen is usually diseased, the result of extra-splenic influences. A palpable spleen is a diseased one. Normally, the spleen enlarges during digestion.

In the first decade of life, there are two entities to which the spleen is liable. The children under 2 1-2 years of adult with an elarged spleen, a lymphacytosis, a variable number of marrow cells. This is the so called Von Jaksch disease or splenic anemia of infancy.

In children over 2 1-2 years of age, with an enlarged spleen, an anemia, with a low red and white blood cell count and a low hemoglobin, the term splenic anemia of childhood has been given.

Splenic anemia in adults is supposed to be due to an infection. It is characterized by an enlarged, adherent spleen, with cell atrophy and a thickened capsule.

In addition to the splenomegaly, there is an anemia of a variable degree, weakness, and often gastric or intestinal hemorrhages. Late in the disease, there is ascites, edema of the lower extremities and an enlargement of the liver, (Banti). Splenectomy usually cures, provided the patient stands the operation itself.

Hyper-spleenism is of two types (1) congenital (2) acquired. The former begins in childhood, may be familial, jaundice is present, there may be colic, the child remains more or less stunted, and the spleen is enlarged. The acquired type comes on later in life, runs a more rapid course, jaundice may be deep, though of the non-obstructive type. There is increased white blood cells, fragility and the disease terminates fatally unless spleenectomy be performed. This procedure is curative.

Gauchers disease is a splenomegaly occurring particularly in children and women. It is pictured by an anemia, a hemorrhagic diathesis (gums, nose etc.) and a distinct bronzing of the exposed cutaneous surfaces. This disease is very rare—only 49 authenic cases yet reported. Arsenic, iron, calcium, blood transfusion and splenectomy have all been resorted to, in an effort to Malaria, tuberculosis and syphilis may produce splenomegaly. The spleen is essentially a blood filter. It removes these organisms from the blood, harbors them for indefinite periods and later from time to time dumps them into the portal circulation causing a re-infection of the liver or the system in general. The distress in either of the three conditions is largely mechanical and promptly disappears after splenectomy.

PUBLIC HEALTH

By R. G. BEACHLEY, M. D., Health Officer, Spartanburg County, Spartanburg, S. C.

SOME SUGGESTIONS FOR THE MENTAL HYGIENE OF CHILDHOOD

Do you wish your child would mind every time you speak?

Have you ever stopped to think why he does not?

1. Perhaps you use a wrong method to secure obedience.

1. Are you careful to gain the child's attention before you tell him what to do? A child who is busy with his play may not know you are talking to him.

2. Do you give many commands without meaning them? The child knows if you do, and soon stops listening to you at all.

3. Do you allow him to do a thing one day and punish him for doing it the next? If the child does not know what he must expect every tmie, he is tempted to take a chance this time.

4. Do you promise a reward if the child obeys? If you have that habit, it is "good business" for him to hold out for a bigger reward.

5. Do you try to scare your child into doing what you want? Fear makes him "step lively" at first, but either he gets used to the object of terror so that it has no effect (even when for his own safety he should be afraid) or he becomes a timid, nervous child. Do you really want either of these results?

6. Do you make disobedience so interesting by the excitement you stir up over it that any child who loves excitement would want to be disobedient?

7. Do you give commands that it is against nature for a child to obey? For instance, do you constantly nag a child at the "little wriggler" age with "Keep still!" "Don't make so much noise!"?

His nervous system needs activity as much as his body needs food.

How much better to give him a chance to be active in some right way!

II. Perhaps you have not thought enough about what one must do to deserve the honor of a little child's trust and obedience.

1. Do you always keep your promise? If you were a child, would you trust a person who deceived you? When trust is gone, obedience goes, too, or is given only because the other person is bigger and stronger.

2. Do you show no favoritism among the children, expecting from each according to his ability and giving to each according to his need?

3. Do you keep yourself from giving commands or punishing in anger? If you are angry, the chances are that the child will be angry, too, and do things he would not do if he were his best self.

4. Do you resist the temptation to make the child obey needless commands for the sake of showing authority? A child knows when you are using authority unjustly and rebels against it if he has the self-respect that is normal even in a little child.

5. Do you consider the child's motive in what he does or solely whether the result is inconvenient for you? A child who makes a mistake trying to help is not naughty just because he happens to break something.

6. Are you careful not to put in your child's way temptations too hard for him to resist at his age? If you punish him too severely, will he not be tempted to lie to save himself? If you leave things about that a child longs for, is it not too much to expect that he will not take them? Father and mother should help him to do right, not make it easy to do wrong.

Have You Thought About Why Children Should Obey Their Parents?

Some Parents obey their children. Such children are apt to grow up to think the world is going to give them everything they want. When they learn differently, it is bitterly hard for them. Some never learn, and in taking

what they want, become the people whom the law has to take in charge.

Some children obey their parents too well. They are not allowed to think for themselves at all and grow up to be helpless men and women who always need some one to tell them what to do.

Is it not far better to teach children to obey the right? For a while they must trust you to tell them what the right is (and you must be very sure that your commands are right and fair and for the child's good), but as they grow older they ought, each year, to be able to know what is right for themselves.

ARE YOU GIVING YOUR CHILDREN THAT RIGHT?

SOCIETY REPORTS

LAURENS COUNTY MEDICAL SOCIETY

Dr. J. W. Davis, of Clinton, was elected president of the Laurens County Medical Association at the annual election of officers held here Monday afternoon. Dr. R. R. Walker, of Laurens, was elected vice-president and Dr. J. L. Fennel, of Waterloo, was elected secretary and treasurer.

Dr. S. C. Hays, of Clinton, and Dr. R. E. Hughes, of Laurens, were elected delegates to the meeting of the state association in Sumter in April. Dr. J. O. Whitten and Dr. J. M. Bearden, of Laurens, were elected alternates.

It was announced that Dr. E. W. Carpenter, of Greenville, will be the guest of the association at its monthly meeting in February.

Dr. W. T. Pace, of Gray Court, and Dr. T. L. W. Bailey, of Clinton, read interesting papers.

J. L. Fennel, M. D., Secretary.

YORK COUNTY MEDICAL ASSOCIATION

York County Medical Association met at Rock Hill on February 9, 1926 at 11:00 o'clock A. M.

Doctors present: Friedheim, Lyle, McDowell, Elliott, McGill, I. A. Bigger, J. R. Miller, Bundy, Simpson, Saye, Hay, Dulin, Massey, Walker, Whitesides, Twitty, Desportes, Blackmon, Bratton, Strait, Ward.

Visitors—Jones of Health Springs, Campbell of Blacksburg, Mahoney and Goudelock of Monroe, N. C.

The society was honored at this meeting by Dr. Robt. S. Cathcart of Charleston, S. C., President of the South Carolina Medical Association, paying his annual official visit.

Dr. E. A. Hines of Seneca, S. C., Secretary of the State Association also paid his official visit at this meeting.

Dr. Joseph Cannon of Charleston, S. C., was a visitor.

Papers read: Dr. E. W. Pressly of Clover was on the program for a paper, but was unable to be present on account of illness. Dr. Cathcart made a very able and instructive talk on subjects vital to the profession and public as well. Discussions by Drs. Miller, Dulin, Ward and Simpson.

Dr. J. I. Barron read a paper on Hook-Worm disease that was good and discussed fully by Drs. Hines, Dulin, Walker and Cathcart.

Dr. Cannon gave an interesting and instructive talk on Periodic Health Examinations. Discussed by Miller, Mahoney, and Massey.

Dr. Hines gave interesting remarks on Periodicals, Books, Etc. Doctor Cathcart emphasized the importance of health examinations—made the point that according to the new allotment of delegates to the American Medical Association, we are entitled to another delegate from the South Carolina Medical Association, to be elected at the Sumter meeting in April. He also brought up the subject of a pending bill in the South Carolina House of Representatives, creating a separate board for examination of nurses before license in this state, consisting of two physicians and three nurses to be a separate board from the present board of medical examiners.

The President appointed the following committees: Drs. Ward, Dulin and Saye to go before the house and oppose this bill for separate board of examiners.

Election of officers: President, W. K. McGill of Clover, S. C.; Vice-President, L. S. Hay of Rock Hill, S. C.; Secretary and Treasurer, Dr. W. C. Whitesides of York, S. C.

Delegates to State Association: Dr. J. B. Elliott, Fort Mill and Dr. W. E. Simpson, Rock Hill.

Alternates: Dr. J. R. Miller of Rock Hill and Dr. J. I. Barron of York.

The name of Dr. William Jones of Health Springs was presented for membership in the York County Medical Association, acted on favorably by Board of Censors, elected for membership and received as a member in the association.

Meeting adjourned to meet in York, S. C. on March 9, 1926.

W. C. Whitesides,
Secretary and Treasurer of
York County Medical
Association.

SPECIAL MEETING

At a Special Meeting of the Medical Society of South Carolina, held at Roper Hospital, Monday, February 1 1926, at 8:30 P. M., Dr. Wythe M. Rhett was elected as the nominee from this Society for appointment to the Board of Health and Welfare in the City of Charleston.

At a recent meeting of City Council, the ordinance establishing a Board of Health and Welfare was amended in such a way as to take the Mayor off this Board, where he had been an ex-officio member, and place in his stead a nominee from the Medical Society of South Carolina (Charleston County), this member to be appointed by the Mayor and confirmed by City Council. The amendment to this ordinance also provides that the Health Officer shall be elected by the Board of Health and Welfare; whereas, heretofore the ordinance had placed this authority in the hands of City Council.

Dr. Rhett's election will add strength to the present Board, and it is believed that he will reflect great credit on this Society.

W. Atmar Smith, M. D. Secretary.

MINUTES

MINUTES OF THE REGULAR MEETING OF THE MEDICAL SOCIETY OF SOUTH CAROLINA, HELD AT ROPER HOSPITAL, TUESDAY, FEBRUARY 9, 1926, AT 8:30 P. M.

The meeting was called to order by the President, Dr. Edward Rutledge.

Present:

Drs. Aimar, Baker, A. E., Jr., Banov, Beach, Brewer, Buist, Burn, deSaussure, Jackson, Johnson, F. B., Kollock McCrady, Maguire, Mood, Plowden, Price, W. H., Price, F. R., Rhame Rhett, R. B., Rutledge, Simons, Smith, J. E., Smith, W. A., Sparkman, Taft, A. R., Wilson, I. R., Wilson, L. A., Zerbst.

The minutes of the Regular Meeting of January 26th and of the Special Meeting of February 1st were read and confirmed.

Dr. T. Grange Simons, Chairman of the Board of Censors, stated that the application of Dr. J. Alex Meldau of McClellanville, S. C., for membership in the Society was disapproved, and in this connection he read the evidence which made the Board of Censors decide to make this adverse report. It was moved, seconded, and carried that the report be received as information and the action of the Censors commended.

Under Candidates to be Balloted for, Dr. Roderick Macdonald's application, which had been approved by the Board of Censors, was voted on. The vote was taken. The President announced that Dr. Macdonald was unanimously elected a member of this Society and instructed the Secretary to inform Dr. Macdonald of his election, urging him to be present at the next regular meeting in order to sign the constitution.

The Secretary read a letter from Dr. J. M. Green, which stated that he had been elected to the position of "Epidemiologist" and that he desired to express his thanks and appreciation to the Society for their co-operation and help during his term of office as Health Officer; that he asked for the same co-operation and support for Dr. Banov, who would succeed him. On motion, this letter was received as information and filed.

The Secretary stated that the Chairman of the Program Committee had asked him to announce that his committee had arranged a program, pursuant to the resolution passed at the meeting of the Society on November 24th, in regard to inviting certain lay members of the community to meet with the Society to consider the health situation in Charleston, and requested that a special meeting be called for this purpose. It was moved, seconded, and carried that a special meeting be called for this purpose. It was moved, seconded, and carried that this meeting be held Wednesday evening, February 17th.

Dr. T. Grange Simons, who has not been present at the meetings of the Society for some time, arose and expressed his appreciation of the letter that he had received from the Society during his illness.

Dr. Leon Banov stated to the Society that he would take over the office of City Health Officer of Charleston on the next day and asked the Society for its support. After Dr. Banov's announcement, the President advised him to read "Arrowsmith."

It being 9:00 P. M., the Scientific Program was called.

A paper on "Choked Disc" was read by Dr. J. E. Smith. Discussed by Drs. Kollock, Taft, Maguire, F. R. Price, E. H. Sparkman, Dr. Smith closing.

A case of Embryoma of the Kidney in a child aged 2 years was presented by Dr. J. S. Rhame and discussed by Drs. Plowden, Buist, and Maguire.

Dr. A. R. Taft presented a roentgenogram of the chest, showing a large mediastinal mass, which he stated he believed to be due to a sarcoma. Discussed by Dr. W. A. Smith.

Dr. L. A. Wilson exhibited a specimen of the uterus which he had just removed for premature separation of the placenta. Discussed by Dr. R. L. McCrady.

There being no further business, the meeting adjourned.

W. Atmar Smith, Secretary.

MINUTES OF A SPECIAL MEETING OF THE MEDICAL SOCIETY OF SOUTH CAROLINA, HELD AT ROPER HOSPITAL, WEDNESDAY, FEBRUARY 17, 1926, AT 8:30 P. M.

The meeting was called to order by the President, Dr. Edward Rutledge.

Present:

Drs. Aimar, Banov, Beach, Beckman, Boette, Buist Burn, Cain, Cannon, Cathcart, Chamberlain, Jackson, Kollock, McCrady, Maguire Martin, Mood, O'Driscoll, Price, W. H., Price, F. R., Rhett, R. B., Rhett, W. M., Rhett, W. P., Rutledge, Simons, Smith, J. E., Smith, W. A., Sparkman, Taft, A. R., Wilson, I. R., Wilson, L. A., Wilson, Robt., Zerbst.

Guests: Mr. Robt. Lathan, Editor, News & Courier; Mr. T. R. Waring, Editor, Charleston Evening Post; Mr. F. L. Godshalk, President; Dr. C. W. Kollock, President; Mr. L. K. Legge, Chairman, Board of Health & Welfare; Dr. Jas. A. Hayne, State Health Officer; Mr. Campbell Bissell, City Council (Representing the Mayor); Dr. J. J. Snyder, M. C., U. S. Navy.

Dr. R. S. Cathcart was asked by the President to state the object of the meeting and open the discussion. Dr. Cathcart spoke as follows:

"Gentlemen:

"Some months ago, at a meeting of this Society, attention was called to the high percentage of infant mortality as pertaining to the City of Charleston. Feeling keenly the seriousness of this situation as affecting the prestige of this community, a very strong committee was appointed to investigate conditions that maintain here and report their findings. This committee worked over a period of several months, making a most exhaustive report to this Society. As a result of this report and its discussion, we felt that the cause of the high infant mortality was not entirely a medical one but primarily a layman's job. It was suggested that this report and its discussion be given to the public press. This was not done, as we felt, coming from this Society, it might be taken as purely a medical problem and not create the deep and continued thought that the condition demands of the public.

"It was deemed best, therefore, to start with a few of the leading people of our city. In selecting the ones before whom we desired to put this matter, the officers of this Society were requested to arrange for a meeting with the mayor of Charleston, the Chairman of the Board of Health, the editors of the two daily papers, and the presidents of the various luncheon clubs —all of you are, and should be leaders of thought in this community. This, gentlemen, is our excuse for imposing on you this evening in giving ourselves the pleasure of having you as our guests.

"To state the object of this meeting, I will very briefly call to your attention some of the things that I have been saying in various sections in South Carolina during the past year. As President of the State Association, I am expected to bring to the attention of the profession throughout the State matters affecting the public generally, and in speaking on the subject of infant mortality as pertaining to South Carolina, I could not do this without giving Charleston's record. As a result of this, I have been asked to introduce the subject this evening.

"'The Evening Herald' of Rock Hill (where I spoke last) quotes me as follows: 'He said, with a feeling of shame, that of all the states in the United States, South Carolina is the blackest spot in the nation so far as infant mortality goes. He said it was a deplorable fact that his home city, Charleston, had the highest infant mortality, not only of any city in the United States, but of any city in North America.'

"Statistics show that South Carolina at the present time has the highest infant mortality of any state in the Union. The infant mortality for South Carolina in 1924 was 109 per 1,000 births. The same for the United States generally was 72. Infant mortality in South Carolina appears higher because of poor birth reporting as many physicians and midwives fail to report births, and as practically all deaths are reported, the percentage is higher than it would be if all births were reported.

"South Carolina has now been dropped from the U. S. Registration Area because of poor reporting of births, and while our state figures show a decrease in our infant mortality for the past year, this figure—92—is not official, and "109" will be accounted our infant mortality until we get back into the Registration Area, and it will take some little while to do this.

"Of course, such figures lower the prestige of this state. The urban infant mortality rate for South Carolina is 122 for 1924. Recently, an editorial appeared in the "Spartanburg Herald" as follows:

'South Carolina is holding first place in the records of infant mortality, and it is highly interesting that this unenviable position is said to be brought about in all probability by the failure of South Carolina physicians to report births. All deaths are reported but not all births, according to the views of those who have made a study of the situation, and quite naturally the death rate among children is thus raised. If this be true, South Carolina physicians will certainly be given a new point of view as to the importance of their thorough co-operation with the health authorities of the state. South Carolina should not rest under the indictment of having the highest infant mortality if that can be removed by accurate vital statistics. The question raised is something for the medical profession of the state to consider seriously.'

This may be true, but if the medical profession did report every birth, it would not correct entirely the high mortality, as for instance: Charleston, where births generally are reported (the U. S. Registration Area gives Charleston a record of over 90 per cent of reporting births, which is high), notwithstanding this, has the highest infant mortality of any city, town, or village, not only in South Carolina, but in the

United States in cities of over 50,000 inhabitants.

In Harper's "Public Health Series," there is included a book written by S. Josephine Baker on "Child Hygiene" from which the following is quoted:

'The infant death rate is one vital index of the state of civilization of a community. In the United States the death rate ranges (in 68 cities, with a population of from 50,000 to 100,000) from 37 in Berkeley, California, to 129 in Charleston, South Carolina. The average rate in the states in the birth-registration area is 76'. "Dr. Baker clai-s that there is no excuse for any community having a baby death rate above 50. And in a few years it should not be above 25. How does your community measure up against this standard? If the rate is high, do you know why? Also, do you know what is being done about it and what can be done about it?"

"If the City is thinking of appropriating money to advertise historic Charleston, how many dollars will it take to correct advertisements of this kind which have gone over the country?

"It will probably be stated that our large negro population raises the mortality rate. This will not answer the question, because the negroes are a part of our population, and conditions which affect our population generally under which they are allowed to exist should be corrected if possible.

"A large percentage of the cause of deaths in infants is due to preventable diseases and preventable conditions. There are a number of conditions which affect infant mortality, notably among them being:

Housing conditions, pre-natal influences, food and milk supplies, etc., the correction or improvement of which will prevent disease. The others who are to follow me will speak more fully of these conditions.

"We are trying to give you a true picture and will ask you, as leaders in this community, what you will do about it. You can teach people to go to their physicians for advice regarding health matters, but they will have to go to others for the correction of housing conditions and the proper investigation of milk and food supplies. This is really the job of the layman, and the thinking people of this city and I hope that you will make it your task ot stimulate them in these matters."

Dr. G. McF. Mood, Chairman of the Committee on Infant Mortality in Charleston, pointed out the salient features of the report of his committee as previously brought out at a meeting of this Society.

Dr. Wythe M. Rhett discussed the bearing that the housing conditions and the unsatisfactory milk supply in Charleston have on the high mortality among infants.

Dr. Robert Wilson pointed out that the high infant mortality was a community problem and was a reflection on the sanitary intelligence of the people. He stressed the layman's responsibility in matters of this kind.

Dr. James A. Hayne, State Health Officer, commented favorably on the excellence of the report made by the Committee and expressed his opinion that much could be done by the application of scientific methods for the correction of conditions.

The report was further discussed by Mr. Robert Lathan, Mr. T. R. Waring, Dr. Leon Banov, and Dr. W. H. Price. Dr. Price pointed out that the high infant mortality was largely due to negro deaths; that the negroes used very little milk; and that it was his opinion that the milk supply contributed little to the high infant mortality.

The report was also discussed by Drs. O'Driscoll, W. A. Smith, and J. H. Cannon.

There being no further business, the Society adjourned.

W. Atmar Smith, Secretary.

ASSOCIATION NEWS ALUMNI HOUSE OF DELEGATES, ETC.

An important campaign to raise an endowment for the Medical College of the State of South Carolina is now in active progress throughout the state under the enthusiastic leadership of Dr. D. L. Smith, Spartanburg, S. C., an alumnus of the institution. A meeting will be held in every county in the state and an organization perfected. Dr. Robert Wilson, Dean, has sent out a letter to every graduate urging cooperation in this worthy enterprise. The entire profession will be interested in a greater medical college. The annual Alumni luncheon will be held at Sumter. This is now an event of state wide importance and will be unusually attractive this year. Every member of the State Association is cordially invited to be present.

A major project of the State Association this year is the periodic health examination demonstration to be conducted by Dr. C. Ward Crampton of the New York Post Graduate Medical School. The State Board of Health has recently sent out to every member of the State Association a copy of the manual of the American Medical Association on how to conduct these examinations. South Carolina is a leader in this phase of preventive medicine.

The House of Delegates will meet on the night of April 6 at 8:00 P. M.

The entertainments this year will be simple and yet ample for social contact. There will be a general reception at the Country Club on the evening of Wednesday, April 7th. The members, wives and daughters will be expected to attend this function.

The Woman's Auxiliary will have its annual meeting as usual and an interesting program provided.

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SOCIETY REPORT
PICKENS COUNTY SOCIETY

The regular meeting of the Pickens County Medical Society, upon invitation of Drs. Peek and Bryson, was held at their new hospital at Six Mile, January 6, 1926. A delicious dinner was served by Mesdames Peek and Bryson, which was evidently enjoyed to the fullest by all who were fortunate enough to be present.

Those present were: visiting, Dr. J. R. Young, District Councilor, Anderson, S. C.; members: Drs. Clayton, Rosamond, Griffin, Bryson, Pepper, Bearden, Woodruff, Peek, Potts and Bolt.

After dinner was served and we had looked through the well appointed hospital, the regular session was opened with prayer. Dr. Young was asked to address the society.

The preliminary remarks of Dr. Young were along the line of general society work and especially emphasizing the part of individual members in carrying out programs, taking part in discussions, committee work or any other duty that might be placed upon them.

After these remarks Dr. Young took as his leading subject, "Fractures of the Skull," giving a synopsis of cases, treated in Anderson County Hospital, with X-ray findings in each case.

A vote of thanks was given Drs. Peek and Bryson and their good wives for the delightful entertainment and to Dr. Young for his splendid address.

Each member left with the feeling that "it was good to be here."

J. L. Bolt, M. D., Secretary.

CORRESPONDENCE

Editor Journal,

We thought, possibly that you would be interested in what we fellows down here in western Clarendon are doing. On the first of the year, we two physicians opened up a medical and surgical laboratory, in which we have been very successful, our community welcomed it, and have offered us any help that we may need to make it a success. We would think all physicians living quite so far from medical centers would find such an undertaking equally as satisfactory as we have. We find the laity anxious for these tests to be made at home and are perfectly willing to pay for same.

W. H. Carrigan & L. C. Stukes.

NEW SILVER COMPOUNDS

The silver salts have lost none of their prestige, notwithstanding the flood of topical antiseptics and germicides which is overflowing the market. On the other hand, certain improvements are being made, with the object of avoiding the irritating or staining features of the older silver compounds.

By an ingenious combination of silver iodide with a gelatinous protein, this salt has been made impervious to the action of sunlight, so that its solutions (or suspensions) do not turn dark on exposure. Thus the staining effect of the silver is avoided. And it would appear from bacteriologic tests made by the manufacturers (tests which, of course, any bacteriologist can repeat) that the germicidal activity of the new silver preparation is at least equal to that of pure carbolic acid; moreover, that, whatever the concentration of the solution, inflamed tissues are not irritated by its application.

The name of the product referred to is Neo-Silvol, and the manufacturers are Parke, Davis & Co. Some of the applications of Neo-Silvol are mentioned in an advertisement which appears in this issue.

Calcreose

In Bronchitis and Tuberculosis

Calcreose confers all the benefits of creosote medication with gastric disturbance largely eliminated.
Calcreose can be given in large doses for long periods without apparent difficulty. Try it.

Powder : Tablets : Solution
Sample of tablets on request

THE MALTBIE CHEMICAL CO. Newark, New Jersey

Florida Sanitarium and Hospital
ORLANDO, FLORIDA

A modern physio-therapy institution, well-equipped laboratory, dietetic and metabolism apparatus for thorough and complete diagnosis and treatment of all chronic diseases. Complete x-ray plant including 210 k. v. apparatus for deep therapy.

Thoroughly qualified physicians and surgeons in constant attendance together with competent corps of nurses give efficient and conscientious service night and day. Battle Creek methods. Quiet homelike atmosphere.

Tubercular and contagious diseases barred.

Located 2 1-2 miles north of Orlando on Dixit Highway overlooking beautiful lake. Capacity 100.

Write for Literature
DR. L. L. ANDREWS, Medical Supt.

WANTED

1000 members for 1926. Only 43 members needed to reach the goal of one thousand enrolled in the South Carolina Medical Association. Success is in sight at last! Slogan for the Sumter meeting "1000 in 1926."

SITUATIONS WANTED

WANTED: Salaried Appointments for Class A Physicians in all branches of the Medical Profession. Let us put you in touch with the best man for your opening. Our nation-wide connections enable us to give superior service. Aznoe's National Physicians' Exchange, 30 North Michigan. Chicago. Established 1896. Member The Chicago Association of Commerce.

500 Times More
Germicidal than Phenol

Metaphen

A Contribution of Research to Medical Practice

For years, chemists in the Dermatological Research Laboratories have been engaged in the study of organic mercurials, particularly in regard to their germicidal properties. The result of this research is METAPHEN. This powerful, mercurial antiseptic is not only 500 times more germicidal than phenol, but is **stainless, odorless,** non-corrosive and practically **non-irritating.**

METAPHEN is the ideal antiseptic and germicide for general surgery due to its exceedingly powerful destructive effect upon bacteria, particularly the staphylococci, streptococci and gonococci.

METAPHEN is decidedly superior to iodine for sterilizing the operative area as well as for treating wounds and infected surfaces. It is an ideal sterilizing agent for surgical instruments.

METAPHEN is also giving remarkable results in eye, ear, nose and throat work as well as in dentistry and general practice.

Ask your dealer or druggist for METAPHEN, D. R. L. Interesting literature will be sent on request to

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